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Submitted via email to TribalAffairs@cms.hhs.gov

Comments of The Rosebud Sioux Tribe Health Administration Office in Support of 100 Percent FMAP Proposal

Health is our most fragile natural resource; without health we are unable to live in a meaningful and productive way. Two-hundred years ago, the Lakota were a self-sustaining and self-governing people able to feed, clothe, and care for themselves. The events of the past 150 years have created the environment and state of health that we live in today. Unfortunately as a result of those events, we have had to struggle to retain our identity and our purpose. These events led to dependence on systems that were not designed with our specific needs in the forefront. This has contributed deeply to the unhealthy way of life that exists in our communities today and has shaped the healthcare delivery systems that serve our people. In order to truly achieve improvements in our health status and well-being, we must first acknowledge and heal from these difficult realities, learn from the mistakes that have been made, and move forward in a unified way.

The Rosebud Sioux Tribe is located on the Rosebud Reservation in south central South Dakota. The main Reservation has a total area of 1,442 square miles, while the total land area and trust lands of the reservation cover 5,961 square miles spread out over approximately 9,750 square miles. It includes 20 communities located in counties of Todd, Mellette, Tripp, Gregory and Lyman. The tribal headquarters is in Rosebud, South Dakota. The people of Rosebud are Sicangu Lakota. Under the terms of the Ft. Laramie Treaty of 1868, the Lakota were placed on one large reservation that encompassed parts of North and South Dakota and four other states. After defeating the Indian tribes in the Plains Wars of the 1870s, the United States confiscated 7.7 million acres of the Lakota people's sacred Black Hills and created several smaller reservations. The Sicangu were assigned to live on the Rosebud Reservation. There are approximately 24,500 enrolled tribal members of whom approximately 80 percent live on the Reservation. In 2014 IHS data reflected 21,388 Indian registrants and an estimated user population of 14,830.

For over 25 years the Tribe has operated a number of IHS programs under its Title I ISDEAA contract with IHS for Comprehensive Health Care Services. These include the Community Health Representative Program, the Emergency Medical and Transportation Services Program, and the Alcohol and Substance Abuse Program. The Tribe's services include ambulatory care, specialty clinic support, inpatient services at the Residential Treatment Center and outpatient substance abuse services, including prevention and education, gambling treatment, referral services and community involvement, and home based services for the acute and chronically ill, the disabled and the elderly. The Tribe operates a youth program known as Piya

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Mani Otipi which identifies high risk youth through screenings and assessments for treatment for substance abuse. The program provides outpatient counseling for youth and families and residential treatment. The Tribe is in its seventh year of operating a Methamphetamine Treatment program which includes assessment, inpatient treatment and aftercare as well as a Suicide Prevention Program know as Tokala Inajinyo.

The Tribe provides through the Ambulance Service advanced life support and full-time basic life support emergency and non-emergency medical care and ground transportation 24 hours per day and 365 days per year. The Tribe also transports on-reservation patients to appointments in-state and out-of-state through the Mini-Bus program. The Ambulance Service transports approximately 50 patients throughout the 20 communities to and from dialysis. Community health representative services include transporting patients to and from appointments at the IHS Rosebud Hospital, home health education, personal and family hygiene and home accident prevention, diabetic and hypertension monitoring, wound care, immunization education, pre- and post-natal care and education, home assessments, substance abuse and mental health referrals and medication delivery and education.

In addition to the programs contracted under Title I, the Tribe oversees multiple grant funded programs including the Diabetes Prevention Program. Independent of the Tribe's ISDEAA and IHS grant activity, in 1998 the Tribe acquired the non-profit White River Health Center, a skilled nursing facility, on the border of two tribal communities. This nursing home has a capacity of 50 residents and is certified by the Centers for Medicaid and Medicare Services (CMS). The Tribe coordinates care with the Rosebud IHS Hospital and other public and private hospitals and clinics in the region. Below are specific comments and recommendations regarding 100% FMAP and Medicaid Expansion we humbly ask you to consider as you consider these changes.

1. Comments on Paragraph 1 – Modifying the Second Condition

The Tribe strongly supports CMS' proposal to decouple 100 percent FMAP reimbursement from Medicaid's facility based reimbursement rules. Section 1905(b) of the Social Security Act does not limit the 100 percent FMAP rule to "facility services" provided in accordance with Medicaid's facility based reimbursement rules. Rather, it applies to all "services" "received through" an IHS or tribally operated facility. 42 U.S.C. § 1396d(b). By its terms, the 100 percent FMAP rule is not limited by Medicaid's facility-based service rules, but rather applies to any service that can be provided in an IHS or tribally-operated facility.

CMS's current policy to limit applicability of 100 percent FMAP to a "facility benefit" is inconsistent with Congressional intent to make 100 percent FMAP available to all "services" that are received through an IHS or tribally-operated facility. As a result, we strongly support CMS'

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proposal to change its existing policy such that any service the IHS or tribal facility is authorized by law to provide could qualify as a service "received through" an IHS/tribal facility. In implementing this change in policy, we urge CMS to clarify that it includes any service authorized under the Snyder Act, the Transfer Act, the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, and other applicable federal law.

We also believe it would be beneficial for CMS to clarify that although the service would have to be encompassed within a Medicaid state plan benefit category and covered under the State's approved Medicaid state plan, a service authorized pursuant to Section 1915 and 1115 waiver authorities would similarly qualify for 100 percent FMAP under this new policy revision.

Finally, although we understand that this revision would not be limited to these services, we strongly support the inclusion of "transportation services, as well as emergency transportation (EMT) services and non-emergency transportation (NEMT), including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements)" as specific examples of covered services. Transportation and associated lodging expenses are a necessary predicate to accessing care throughout Indian country and an integral component in the provision of services in many areas of Indian country. We strongly urge CMS to include transportation and lodging and related services as eligible for reimbursement at 100 percent FMAP as a service "received through" and IHS/tribal facility.

Recommendation:

We support this proposal.
CMS should clarify that a service the IHS/Tribal facility is authorized to provide is any service authorized under the Snyder Act, the Transfer Act, the Indian Health Care Improvement Act, the Indian Self-Determination and Education Assistance Act, or other applicable federal law.
CMS should clarify that services provided pursuant to Section 1915 waivers and 1115 demonstrations would also qualify under this proposal.
CMS should retain and highlight that services covered include "transportation services, as well as emergency transportation (EMT) services and non-emergency transportation (NEMT), including related travel expenses (such as meals, lodgings, and cost of an attendant pursuant to federal and state requirements)."

2. Comments in Response to Paragraph 2 – Modifying the Third Condition

We also strongly support CMS's proposal to modify the third condition so that referral services would be eligible for reimbursement at 100 percent FMAP even if provided by contractual agents outside the four walls of the IHS/Tribal facility so long as there is a connection to the

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IHS/tribal facility. Doing so will increase access to needed care while increasing coordination of care through the Indian health system.

Referrals are a necessary and integral part of the services received through Indian health system, which often either lacks the capacity to provide specialty services, or lacks the ability to provide such services within reasonable economies of scale. Accordingly, referral services should be covered by 100 percent FMAP to the same extent as direct care services.

CMS' interpretation of the 100 percent FMAP rule has been overly restrictive to date, particularly with regard to referrals. The 100 percent FMAP rule provides:

"the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization...."

42 U.S.C. § 1396d(b).

When it enacted the rule, Congress stated it would apply to all services "received through" an IHS or tribally-operated facility. Congress did not limit it to all services "provided in" an IHS or tribally-operated facility, although it certainly could have done so, as it did elsewhere in the very same statute. See, e.g., 42 U.S.C. § 1396(c). Yet Congress clearly intended the phrase "received through" to require that a service have some connection to an IHS or tribally-operated facility. It is a limitation designed to prevent application of the 100 percent FMAP rule for services received by a Medicaid enrolled IHS beneficiary at a non-IHS provider when there is no connection to an IHS or tribally-operated provider. For example, the use of the phrase "received through" would prevent the rule from applying if an IHS beneficiary were to seek services at a non-IHS or tribally-operated provider if there were no referral connection or contact of any kind with an IHS or tribally-operated facility.

As a result, we strongly support CMS's proposal to modify the third condition to expand the meaning of a contractual agent so that referral services to outside providers would be eligible for 100 percent FMAP reimbursement so long as there is a connection to the IHS/tribal facility. Doing so could significantly increase access and coordination of care for IHS beneficiaries across the country. It would allow Tribes and tribal organizations to work with their States on a State-by-State basis to make additional Medicaid services available, or reduce limits on existing Medicaid benefits, through referrals. Every new Medicaid service made available through referral through the IHS or tribally-operated facility due to the revised application of the 100 percent FMAP rule will result in significant savings to already stretched and inadequate purchased/referred care budgets. Those savings could then be put to immediate use by increasing priority levels of care that can be provided through the purchased/referred care program, and result in greater access to care for our beneficiaries. This will not only better serve Indian patients, but also help make the delivery of health care more efficient by freeing up resources to provide lower cost preventative services.

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While the statute dictates that a referral must have a connection to an IHS or tribal program, we urge CMS to implement this requirement in a manner that allows for maximum flexibility for tribes to work out the particulars of the necessary arrangements with their States on a State by State basis. This flexibility is needed so that the availability of 100 percent FMAP for referral based services provides an incentive sufficient to allow States to authorize additional services or expand Medicaid and for IHS/Tribal health programs to develop referrals processes that appropriately expand access balanced by maintaining continuity of care. While we recognize the need for a referral to maintain a connection to the IHS or tribal program to qualify for 100 percent FMAP, we urge CMS not to impose a host of requirements dictating how that connection must be made and maintained. As a result, we believe that CMS's draft proposal should be clarified in several ways.

First, the proposal states that a contractual agent could include an enrolled Medicaid provider "who provides items or services not within the scope of a Medicaid "facilities services" benefit but within the IHS/Tribal facility authority...." We believe CMS's intent in this clause is to clarify that the services that could be provided by the contractual agent would not be limited by the Medicaid "facilities services" rule, as CMS has proposed in Paragraph 1, but would include any service the IHS/tribal facility is authorized to provide. However, this clause could also be read to mean that it does not include services within the scope of a Medicaid "facilities services" benefit, which would preclude hospital, nursing home, residential psychiatric treatment centers and other facilities from qualifying. Again, we do not believe this was CMS' intent, as it would be inconsistent with the proposal in Paragraph 1, and would defeat the goals sought to be achieved by CMS's proposal. CMS should clarify this when it finalizes its proposal.

Second, the proposal would require a "written contract" between the IHS/tribal facility and "contractual agents." While a written contract may be the best mechanism to ensure the requisite connection between the IHS/tribal facility and the contractual agent, it is unrealistic to believe that IHS/tribal providers could obtain written contracts with every referral provider they use. Our concern is that many providers or provider groups simply will not enter into such contracts in circumstances in which there would be no incentive for them to do so. This will lessen the incentive for States to expand services. In addition, many IHS and small tribal health facilities lack the administrative capacity to negotiate and enter into such agreements in a timely manner. A better approach, in our view, would be to require only that the IHS/tribal facility provide a written referral which would provide that as a condition of accepting the referral, the provider would have to provide materials and records back to the referring IHS/tribal facility. We also believe that this latter requirement could be addressed through Medicaid conditions of enrollment, which would improve follow-up to referrals generally. Finally, we believe that the form of written referral must be flexible. Examples of situations that would appropriately be treated differently include allowing for general referrals when the IHS/Tribal health program has extremely limited services (such as in purchased/referred care dependent areas), more focused referrals when the beneficiary has

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been a patient of the referring IHS/Tribal health program, and even written referrals delivered after the care was provided in cases of urgent or emergency situations.

Third, the proposal would require that the contract provide that the Medicaid services be "arranged and overseen" by the IHS/Tribal facility, and the individuals served by the contractual agent would have to be considered patients of the IHS/tribal facility. It goes on to state that "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual." While we appreciate the reasoning behind these conditions, we are concerned that the requirement that the referred patient be considered a "patient" of the IHS/Tribal facility and that the IHS/Tribal facility must retain responsibility for the provision of services as conditions of participation in Medicaid and Medicare that cannot practically be fulfilled during episodes of care provided outside the facility by providers who have their own duty of care to patient. In addition, we are concerned that the examples listed as required for IHS/Tribal facilities to retain responsibility for the provision of services are somewhat ambiguous. If read literally they could impose such administrative burdens and programmatic difficulties as to be unworkable in practice, and could defeat the purpose of CMS' proposal to increase access to care and coordination of services.

We are also concerned that the use of the phrase "arranged" suggests that a patient must seek primary care services within the IHS/Tribal system in order for the 100 percent FMAP rule to attach. While most referral services do begin with a primary care visit within the four walls of an IHS/Tribal health facility, in many cases, particularly those involving an episode of care, a return visit to the IHS/Tribal health facility may not be medically warranted and would likely merely increase the cost of the care. We strongly urge CMS not to implement the rule in a manner that could be interpreted as requiring a primary care visit within the four walls of an IHS/Tribal facility before a referral could qualify for 100 percent FMAP.

A better approach, in our view, would be to implement this requirement in a manner that allows for an AI/AN to be considered a patient in the IHS/Tribal facility in their service area. We urge CMS to adopt an approach that would allow Tribes and States to define the parameters and recordkeeping and reporting requirements referral providers would need to make back to the IHS/Tribal facility on a State-by-State basis.

Recommendation:

We support this proposal, with clarification.

CMS should revise the phrase "who provides items or services not within the scope of a Medicaid "facilities services" benefit but within the IHS/Tribal facility authority...." so that it is not susceptible to an interpretation that it is intended to disqualify Medicaid facilities services benefits, but rather to express clearly that it is intended to be consistent with the policy change proposed in Paragraph 1.

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Rather than requiring a written contract in all cases, CMS should allow a written referral that would provide that as a condition of accepting the referral, the provider would have to provide materials and records back to the referring IHS/tribal facility. CMS should not include the phrase "[t]he IHS/Tribal facility would need to retain responsibility for the provision of services, meaning that the IHS/Tribal facility must retain control of the medical records, including updating medical records with information from care provided by contractual agents and providing care coordination for the AI/AN individual" or similar such conditions, and should not require that an AI/AN be considered a "patient" of the IHS/Tribal facility.

CMS should not suggest that the IHS/Tribal facility must "arrange" for the provision of services, and should clarify that a referral can be considered to have been "received through" and IHS/Tribal facility even if the patient did not first obtain primary care or physical treatment within the four walls of an IHS/Tribal facility for a specific referral or episode of care.

CMS should clarify that a referral to a contractual agent may be made for a specific treatment, an episode or care, or be a standing referral.

CMS should adopt an approach that gives tribes in each State the opportunity to work with their States to develop the type of referral arrangement and requirements that best suit the relationship between the IHS/Tribal facilities in the State and outside providers.

3. Comments in Response to Paragraph 3 – Modifying the Fourth Condition

We strongly support CMS's proposal to allow IHS/Tribal facilities the choice of whether they will bill the State Medicaid program directly for services referred to outside contractual agents, or allowing the contractual agent to bill the State Medicaid program directly for the service. Many tribal health programs have already entered into arrangements with outside providers in which they accept assignment from those outside providers and then bill Medicaid directly for those services. Any change in policy must be careful to allow tribal health programs to maintain such arrangements if they elect to do so. It is equally important, however, to allow contractual agents to bill Medicaid programs directly, as doing so may often be the most administratively simple mechanism, and will avoid complications due to differences in rates applicable to the provision of services within an IHS/Tribal facility and those applicable to non-IHS/Tribal providers under the State plan. Allowing IHS/Tribal facilities the choice between these two options will allow them to work with the other providers in their area to find the alternative that works best for both parties.

Recommendation:

We strongly support this proposal.

4. Comments in Response to Paragraph 4 – Application to Fee-for-Service

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CMS's proposal clarifies that services that are of the type encompassed within the applicable (Medicaid) facility benefit, an IHS/Tribal facility would receive payment at the rate applicable for IHS facilities in the State plan. Services that could be furnished pursuant to IHS/Tribal authority but that are not within the applicable facility benefit would be paid at the State plan rates applicable to those services. Examples provided include personal care, home health, 915(c) waiver services and non-emergency medical transportation. However, CMS notes that "states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services." This last sentence is critically important, as it recognizes the authority of States to establish payment rates that sufficiently reimburse for the provision of services, and allows them continued flexibility in setting those rates. We support this proposal, and strongly recommend that CMS retain this language in the document it finalizes.

Recommendation:

We strongly support this proposal.
CMS should retain and highlight the language it used in its proposal that "states retain flexibility in establishing economic and efficient payment rates to sufficiently reimburse for the provision of services."

5. Comments in Response to Paragraph 5 – Application to Managed Care

The Tribe appreciates CMS's effort to clarify that states may claim 100 percent FMAP for that portion of any capitation rate they pay to a managed care plan that represent services provided to AI/AN individuals enrolled in a managed care plan. It is our understanding that states may already do so, and as a result we appreciate CMS clarifying this point. Under CMS's clarified policy, "states would be permitted to claim the 100 percent FMAP for a portion of the capitation payment for AI/AN individuals who are enrolled in managed care, even though the State itself may make no direct payment for IHS/Tribal facility services." We strongly endorse this approach. While AI/AN are exempt from mandatory enrollment in managed care systems, States are increasingly seeking to adopt managed care for all or parts of their Medicaid and CHIP programs, and in some circumstances it may be advantageous for AI/AN to enroll in managed care to obtain enhanced benefits. As a result, we strongly support this clarification, but urge that CMS further clarify that it applies to managed care systems adopted either by state plan amendment or through a demonstration waiver.
CMS proposes to condition receipt of 100 percent FMAP to only the portion of the capitation rate for which the following conditions are met:

1. The service is furnished to a Medicaid-eligible, enrolled, AI/AN individual;

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2. The IHS/Tribal facility provides the service, either directly or through a contractual agent, and maintains oversight responsibility as discussed elsewhere in the proposal; and
3. The service is payable under the managed care plan and is, in fact, paid by the managed care plan.

The Tribe appreciates that these conditions are designed to ensure that 100 percent FMAP payments would be conditioned on (1) it being a service "received through" the IHS/Tribal facility in a manner consistent with CMS's revised policy; and (2) the Managed Care plans actually making a payment for the service. These conditions ensure that 100 percent FMAP reimbursement is made for services "received through" the IHS/Tribal facility, and are designed to provide an incentive to the States to ensure that managed care plans make payments for services provided to AI/AN. While we support this goal, we have some concern about how it would be operationalized. The proposal goes on to state "that the portion of the managed care payment eligible to be claimed at 100 percent FMAP must be based on actual expenditures incurred for IHS/Tribal encounters." We are somewhat concerned that imposing a tracking requirement on both the managed care plans and the States as a condition of 100 percent FMAP applying could serve as a disincentive to including expanded services for IHS/Tribal facilities through managed care systems. The managed care plans will have little or no incentive to track payments made for services provided to AI/AN, unless the States provided them with one. As a result, if CMS retains these conditions, we believe it will be helpful to clarify that States would retain the flexibility in designing managed care plans (through waivers or otherwise) in a manner that allows them to incentivize managed care plans through administrative claiming mechanisms or otherwise to provide the information States would need to claim 100 percent FMAP for those portions of the capitation payments they make for such services.

It will also be equally important to ensure that any policy provides States with sufficient flexibility so that they can claim 100 percent FMAP without having to meet burdensome tracking and reporting requirements on a case by case or referral by referral basis. In order for this policy to properly incentivize States, they must be given the flexibility to account for care provided to AI/AN on an annual or quarterly basis based on metrics such as the AI/AN service population enrolled in managed care and average encounter data, rather than requiring tracking and reporting on an a per encounter or per referral basis.

Recommendation:

We strongly support this proposal, with clarification.
CMS should clarify that the 100 percent FMAP reimbursement applies to capitation payments made for services "received through" IHS/Tribal facilities in managed care systems established by state plan amendment or waiver authority

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CMS should allow States flexibility in ensuring that services are in fact paid by the managed care plans by allowing them continued flexibility to provide managed care plans incentives they need to provide information back to the State to assist them in claiming 100 percent FMAP, and flexibility in determining the total estimate of payments made for services "received through" IHS/Tribal facilities based on aggregated, rather than per referral or per encounter data.

Our hope is that who we are, what we currently offer and our needs are all weighed when deciding on this very important topic. This change has the potential to bridge some very large gaps in services for our people, it has potential to strengthen current services we provide and increase sustainability of our programs. Lila Wopila Tanka (Thank you very much) for this opportunity and for allowing us to share our voice.

Respectfully Submitted,

Evelyn Espinoza, RN BSN
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